

**Missouri Vaccines for Children Program
LPHA Vaccine Transfer/Replacement Report**

I. PROVIDER INFORMATION

FROM:

Provider Name _____

Address _____

City, State, Zip _____

Telephone Number _____

PIN Number _____

TO:

Provider Name _____

Address _____

City, State, Zip _____

Telephone Number _____

PIN Number _____

II. THESE VACCINES ARE BEING: ____ TRANSFERRED to another clinic ____ REPLACED from private purchase

TIME OUT: _____ **TEMPERATURE OUT:** _____ **TEMPERATURE IN:** _____

VACCINE	# OF DOSES	LOT NUMBER	MANUFACTURER	EXP. DATE	DATE TRANSFERRED
DTaP					
DTaP/HB/IPV (<i>Pediarix</i>)					
DTaP/Hib/IPV (<i>Pentacel</i>)					
DTaP/IPV (<i>Kinrix</i>)					
DT (< 7 years)					
EIPV (<i>IPOL</i>)					
Hep A					
Hep B					
Hib					
HPV					
MCV4					
MMR					
Pneumo-23					
PCV-7 (<i>Prevnar</i>)					
PCV-13 (<i>Prevnar</i>)					
Rotavirus					
Td (Booster)					
Tdap					
Varicella					
Influenza (Pediatric)					
Hep A-Adult (LPHA only)					
Hep B-Adult (LPHA only)					
Hep A/B (<i>Twinrix</i>) (LPHA only)					
MCV4 (<i>Menactra</i>) (LPHA only)					
MMR-Adult (LPHA only)					
Td-Adult (LPHA only)					
Tdap-Adult (LPHA only)					
Varicella-Adult (LPHA only)					

III. TRANSFER AUTHORIZATIONS - Provider Contact(s)/Immunization Quality Manager as required (Replacement)

Signature of Person Transferring Vaccine: _____

Signature of Person Receiving Vaccine: _____

INSTRUCTIONS on reverse side

INSTRUCTIONS

Definitions:

Transfer Vaccine: This occurs when one provider gives VFC vaccines to another VFC provider. (There is no cost incurred by the “transferring” or “receiving” provider.)

Replacement Vaccine: This occurs when vaccine is purchased from a private source for the purpose of replacing VFC vaccine that was negligently wasted (as determined by VFC program staff).

Transferring VFC Vaccine from One Provider to Another

- Section I.** (FROM: section) Please list information for the provider who is transferring vaccine.
(TO: section) Please list information for the provider receiving vaccine.
- Section II.** Check “**transferred**” and complete the required information listed in each column for all vaccines being transferred.
- Document the time vaccine was packed for transfer
 - Document temperature of vaccine once packed in the transport container
 - Document the temperature of vaccine upon arrival at the receiving clinic
- Section III.** **Person transferring** vaccine signs where indicated (**left side**).
Person receiving vaccine signs where indicated (**right side**).

Replacement of VFC Vaccine from Privately Purchased Source

- Section I.** Complete your provider information in **first column only**.
- Section II.** Check “**replaced**” and complete the required information listed in each column for all vaccines being replaced.
- Section III.** **Provider contact person** signs in the “transferring” section (**left side**).
No signature required for receiving replacement vaccine (right side).
- Private purchase invoice is faxed to your VFC County Liaison at 573-526-5220 with front side of replacement report completed as instructed
 - Immunization Quality Manager may validate transfer by signing (**right side of form**) if available

Contact the VFC Program (800-219-3224) if you have questions

REMEMBER

Record the information from this transfer/replacement report on your monthly accountability sheet.

If “**Replacing or Receiving**” vaccine list the number of doses received for each vaccine on **line 2, Vaccine Received** column of your monthly accountability form.

If “**Transferring**” vaccine to another clinic list the number of doses transferred for each vaccine on **line 3, Vaccine Transferred Out** column of your monthly accountability form.

Fax the Vaccine Transfer/Replacement Report with your VFC monthly accountability to **(573) 526-5220**.